be seen that it is more oblique, and that it descends lower at its free extremity than that of the opposite side. Much more rarely the tenth rib appears pressed down a little in some patients, and, as a consequence of the sinking of the diaphragm, the liver usually projects beyond the ribs.

The immobility of the hypochondrium is not constant, and it has not the necessary relation with the purulent character of the effusion affirmed by some physicians. To this immobility is added, sometimes, a sort of retraction of the linea alba and of the umbilicus, which at each inspiration seems to draw them from the side opposite to the immobilized hypochondrium; further, when the region of the flank corresponding to the diseased pleura is held in the hand, immediately below the ribs, if the diaphragm be pressed down by an effusion, a resistance and fulness are felt which are not found in the other flank.

Dr. Gueneau de Mussy has found in two cases that the hollow [saddle-shape] of the flank tends to be effaced, and that this region, instead of offering a concavity, forms almost an upright plane between the iliac crest and the costal border, the distance of which is diminished.

Percussion gives a sound with a sharp tone, a little tympanitic, in a semicircular band which corresponds to the part of the lower lobe of the lung contiguous to the effusion. On auscultation, the vesicular sound at the level of the collection of liquid is, in general, less strong, less full, and sharper than in the rest of the lung; it is sometimes mixed with crepitant or mucous râles, which indicate a congestive state of the pulmonary tissue about the seat of effusion. The weakness of the respiratory sound, followed by prolonged expiration, although more pronounced at the base, may exist in the whole lung of the diseased side, and depend then upon the compression of the principal branches by an enlargement of the tracheo-bronchial glands which ordinarily accompanies diaphragmatic pleurisy.

All these signs lessen the obscurity which enshrouded this affection in the time of Laënnec, and Dr. Gueneau de Mussy states that he has had, many times in the course of thirty years, occasion to verify their exactness. He has frequently seen a pleurisy, which in its first stage he had recognized to be limited to the diaphragmatic region, generalize and become thoracic at the same time that the functional troubles diminished; in other cases, necropsy has given an indisputable confirmation to the diagnosis formed.—*London Med. Record*, Nov. 15, 1879.

Case of Interrupted Respiration, due to the Movements of the Heart.

Two explanations have been commonly put forward to account for the occurrence of interrupted respiration: 1. That the bronchi in certain parts of the lung are narrowed, either by swelling of their mucous membrane or through compression by tuberculous deposit, and the access of air to these portions is therefore rendered more difficult, and their dilatation follows a little later than that of the healthy pulmonary tissue; 2. That it is a form of pleural friction, observed at the onset of pulmonary tuberculization, where the partial pleurisy of the apex interferes with the respiratory movements, or where the pleural friction adds a sound to that of respiration, which is confounded with it. Latterly, M. Potain has maintained that this form of respiration is an attenuated extracardiac bruit. LEREBOULLET, although recognizing the justness of the two preceding explanations, gives an instance (*L'Union Médicale*, Oct. 2, 1879) which appears to support M. Potain's view. The case was one of pulmonary tuberculization, in which there was heard an expiratory sibilant blowing sound all over the chest, following the cardiac rhythm. The patient presented the signs of tuberculous infiltration of the left apex, dulness, bronchial breathing, and some humid râles. Subsequently, additional signs of a congestive attack occurred on both sides, when it was noticed that the two last thirds of the expiratory murmur were replaced by a respiratory bruit of a sibilant character, harsh and less musical than bronchial sibilus. It appeared brusquely during expiration, and partook of the cardiac rhythm, so that at each expiration one heard two or four, most frequently three, sibilant sounds, separated by a scarcely appreciable interval. It could be heard all over the front of the left chest, also in the lateral region, and over the heart. This peculiar sound disappeared if the patient sat up in bed; but on making the patient lie on his belly the same phenomena reappeared over the right base, and also all over the left lung behind. On listening over the larynx it was also found that the expiration was terminated by three or four râles, synchronous with the cardiac movements. There was no cardiac disease. He accounts for this sound by the fact that, during expiration, the thoracic walls being more contracted than during inspiration, the compression of the heart on the lung is greatest, and that thus the heart compresses a sufficient number of pulmonary cells to give rise to a current of air capable of generating in the large bronchi, and even in the trachea, an interrupted expiratory sound, which can be heard even on auscultating the larynx.—*London Med. Record*, Nov. 15, 1879.

Heart Diseases Associated with Scarlatina and Measles.

Dr. Arthur Ernest Sansom, Assistant Physician to the London Hospital, presents (*Med. Times and Gazette*, Oct. 25, 1879) the following statement of the relation existing between heart disease and scarlatina and measles:—

It appears to me evident that scarlatina, occurring in a healthy child, may be a cause disposing to cardiac disease—pericarditis, or endocarditis; and this sometimes with, and sometimes without, the manifestation of distinct rheumatic phenomena. From the evidence before us, I think we may conclude that the probabilities are against the view that the heart disease is due to the *direct* operation of the zymotic poison. We find that it is not developed with any signs of pyrexia; that it is not associated with the zymotic disease in the acute period of manifestation of the latter; that it may occur after the lapse of periods during which symptoms of indefinite ill-health may be manifested in varying degrees of remoteness from the original attack. The forms of disease seem to bear a striking resemblance to those occurring in association with rheumatism, and we have not to seek far in order to find the link which associates the morbid conditions in the one case with those in the other. In rheumatism there is strong reason to believe that the phenomena are due to the retention in the blood of lactic or uric acid and allied excrementitious products. In scarlatina the blood is loaded with material that should, in normal conditions, be excreted; moreover, elimination is peculiarly difficult, so that with increased production there is impeded excretion, and uric acid and other effete products are retained in the circulation to work their toxic effects. The most important post-scarlatinal phenomena are (1) rheumatism and (2) albuminuria. Dr. Mahomed has called attention to the correlation of these.[1] Both complications appear frequently to be induced by the same cause—constipation or chill. This is but a superadded difficulty to an already defective elimination. The blood surcharged with effete products reacting on the fibrous structures of the joints may induce the pain and swelling of articular rheumatism, or it may influence the pericardium or endocardium to produce pericarditis or endocarditis. Or the reaction of the poisoned blood may be more pronounced upon the kidney, and then we have transudation first of the crystalloids, afterwards of the colloids, into the urine. There is albuminuria and renal

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[1] Etiology of Bright's Disease and the Pre-albuminuric Stage.—*Medico-Chirurgical Transactions*, vol. lvii. page 197, and *Am. Journ. Med. Sci.*, April 1875, p. 486.